SB3916

LRB10225820KTG35162b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

SB3916

Introduced 1/21/2022, by Sen. Celina Villanueva

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1
305 ILCS 5/5A-12.7

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires managed care organizations (MCOs) to pay a clean claim (rather than claim) within 30 days of receiving a claim. Defines "clean claim" as a claim that contains all the essential information needed to adjudicate the claim or a claim for which a managed care organization does not request within 30 days of receipt any additional information to adjudicate the claim. Contains provisions concerning MCO reports to providers on the receipt and payment of claims; MCO data collection requirements; providers' right to file suit to recover outstanding payments; quarterly audits of each MCO's requests for provider information to adjudicate claims; MCO claims processing and performance analysis; quarterly audits of MCOs payments to hospitals; the segregation of State-issued Medicaid funds received by MCOs for payments to providers; and other matters. Amends the Hospital Provider Funding Article of the Code. Requires the Department of Healthcare and Family Services to calculate, at least quarterly, all Hospital Assessment Program-related funds paid to each hospital, whether paid by the Department or an MCO, including the amounts integrated into rate increases and distributed as provided under the Code.

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A BILL FOR

AN ACT concerning public aid.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Public Aid Code is amended by changing Sections 5-30.1 and 5A-12.7 as follows:

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

"Clean claim" means: (i) a claim that contains all the essential information needed to adjudicate the claim or (ii) a claim for which a managed care organization does not request within 30 days of receipt any additional information to adjudicate the claim. A resubmitted claim shall be considered a clean claim on the resubmission date if it meets the foregoing criteria.

"Managed care organization" or "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

"Emergency services" include:

(1) emergency services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(2) emergency medical screening examinations, as defined by Section 10 of the Managed Care Reform and

Patient Rights Act;

(3) post-stabilization medical services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act; and

(4) emergency medical conditions, as defined by Section 10 of the Managed Care Reform and Patient Rights Act.

(b) As provided by Section 5-16.12, managed care organizations are subject to the provisions of the Managed Care Reform and Patient Rights Act.

(c) An MCO shall pay any provider of emergency services that does not have in effect a contract with the contracted Medicaid MCO. The default rate of reimbursement shall be the rate paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates.

(d) An MCO shall pay for all post-stabilization services as a covered service in any of the following situations:

(1) the MCO authorized such services;

(2) such services were administered to maintain the enrollee's stabilized condition within one hour after a request to the MCO for authorization of further

post-stabilization services;

(3) the MCO did not respond to a request to authorize such services within one hour;

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

(e) The following requirements apply to MCOs in determining payment for all emergency services:

(1) MCOs shall not impose any requirements for prior approval of emergency services.

(2) The MCO shall cover emergency services provided to

enrollees who are temporarily away from their residence and outside the contracting area to the extent that the enrollees would be entitled to the emergency services if they still were within the contracting area.

(3) The MCO shall have no obligation to cover medical services provided on an emergency basis that are not covered services under the contract.

(4) The MCO shall not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's screening and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the provider actually treating the enrollee, of whether an enrollee is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover emergency services for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider.

(6) The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

(A) a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(B) a plan physician assumes responsibility for the enrollee's care through transfer;

(C) a contracting entity representative and the treating physician reach an agreement concerning the enrollee's care; or

(D) the enrollee is discharged.

(f) Network adequacy and transparency.

(1) The Department shall:

(A) ensure that an adequate provider network is in place, taking into consideration health professional shortage areas and medically underserved areas;

(B) publicly release an explanation of its process for analyzing network adequacy;

(C) periodically ensure that an MCO continues to have an adequate network in place;

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3; ~~and~~

(E) require MCOs to ensure that any Medicaid-certified provider under contract with an MCO and previously submitted on a roster on the date of service is paid for any medically necessary, Medicaid-covered, and authorized service rendered to any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available directory of available providers; and~~.~~

(F) ~~(E)~~ require MCOs, including Medicaid Managed

Care Entities as defined in Section 5-30.2, to meet each of the requirements under subsection (d-5) of Section 10 of the Network Adequacy and Transparency Act; with necessary exceptions to the MCO's network to ensure that admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in paragraph (3) of subsection (d-5) of Section 10 of the Network Adequacy and Transparency Act is limited to providers or facilities that are Medicaid certified.

(2) Each MCO shall confirm its receipt of information submitted specific to physician or dentist additions or physician or dentist deletions from the MCO's provider network within 3 days after receiving all required information from contracted physicians or dentists, and electronic physician and dental directories must be updated consistent with current rules as published by the Centers for Medicare and Medicaid Services or its successor agency.

(g) Timely payment of claims.

(1) The MCO shall pay a clean claim within 30 days of receiving a claim ~~that contains all the essential information needed to adjudicate the claim~~.

(2) The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.

(2.5) At the time of payment for a claim, MCOs shall report to the provider (i) the date of receipt of the claim by the MCO; (ii) the date of payment of the claim; and (iii) whether the MCO considers the claim to have been a clean claim.

(2.6) MCOs shall provide to safety-net hospitals on a monthly basis a report of all claims paid the preceding month stating (i) the dates of receipt and payment of each of the claims and (ii) whether the MCO considers the claim to have been a clean claim. The reports shall be provided in both portable document format (PDF) and Excel spreadsheet formats.

(2.7) MCOs shall collect and maintain the following data for each claim submitted by a provider:

(A) the date the claim was received by the MCO;

(B) if applicable, the date any additional information was requested by the MCO;

(C) if applicable, the date additional information was received by the MCO;

(D) the date the claim was adjudicated; and

(E) the date the claim was denied or paid. MCOs shall provide this data to any individual provider that requests it, within 30 days after receiving the provider's written request.

(3) The MCO shall pay a penalty that is at least equal to the timely payment interest penalty imposed under

Section 368a of the Illinois Insurance Code for any claims not timely paid.

(A) When an MCO is required to pay a timely payment interest penalty to a provider, the MCO must calculate and pay the timely payment interest penalty that is due to the provider within 30 days after the payment of the claim. In no event shall a provider be required to request or apply for payment of any owed timely payment interest penalties.

(B) Such payments shall be reported separately from the claim payment for services rendered to the MCO's enrollee and clearly identified as interest payments.

(C) Each MCO, including any owned, operated, or controlled by any governmental agency, shall pay interest for untimely payment of claims in accordance with this subsection.

(3.1) On a quarterly basis, and within 30 days after the end of each calendar quarter, each MCO shall report to the Department the following information on a provider-by-provider basis for each provider that submitted 20 or more Medicaid claims to the MCO in the quarter:

(A) the total number of claims received from the provider during the prior quarter;

(B) the percentage of all such claims that were

clean claims;

(C) the percentage of all claims the MCO paid within 30 days of receiving the claim;

(D) the percentage of all claims the MCO paid within 90 days of receiving the claim;

(E) the percentage of all clean claims the MCO paid within 30 days of receiving the claim; and

(F) the percentage of all clean claims the MCO paid within 90 days of receiving the claim.

Such information shall be provided by the Department to the provider to whom the data applies within 14 days of request by the provider.

(3.2) The provisions of this subsection, and others dealing with timely payment of claims, are intended for the benefit of the Department and of the providers. The Department and each provider shall have the right to bring suit in any court of competent jurisdiction to enforce these provisions, including recovery of payments due to providers, and to obtain any information related to individual providers required to be provided under this subsection. The court may enter any appropriate compensatory, declaratory, or injunctive relief. In any action or proceeding to enforce this subsection, the court shall have the authority to award the prevailing party all fees and costs incurred, including attorneys' fees.

(3.3) On a quarterly basis, the Department shall audit

a representative sample of each MCO's requests for information from providers to determine whether the requested information is necessary to adjudicate the claim. If the Department determines that the MCO requested information that was not necessary to adjudicate the claim, the MCO shall be required to pay a penalty to the Department and interest to the provider computed from the date of the submission of the claim to the MCO.

(4)(A) The Department shall require MCOs to expedite payments to providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), on a schedule at least as frequently as the providers are paid under the Department's fee-for-service expedited provider schedule.

(B) Compliance with the expedited provider requirement may be satisfied by an MCO through the use of a Periodic Interim Payment (PIP) program that has been mutually agreed to and documented between the MCO and the provider, if the PIP program ensures that any expedited provider receives regular and periodic payments based on prior period payment experience from that MCO. Total payments under the PIP program may be reconciled against future PIP payments on a schedule mutually agreed to between the MCO and the provider.

(C) The Department shall share at least monthly its expedited provider list and the frequency with which it

pays providers on the expedited list.

(g-5) Recognizing that the rapid transformation of the Illinois Medicaid program may have unintended operational challenges for both payers and providers:

(1) in no instance shall a medically necessary covered service rendered in good faith, based upon eligibility information documented by the provider, be denied coverage or diminished in payment amount if the eligibility or coverage information available at the time the service was rendered is later found to be inaccurate in the assignment of coverage responsibility between MCOs or the fee-for-service system, except for instances when an individual is deemed to have not been eligible for coverage under the Illinois Medicaid program; and

(2) the Department shall, by December 31, 2016, adopt rules establishing policies that shall be included in the Medicaid managed care policy and procedures manual addressing payment resolutions in situations in which a provider renders services based upon information obtained after verifying a patient's eligibility and coverage plan through either the Department's current enrollment system or a system operated by the coverage plan identified by the patient presenting for services:

(A) such medically necessary covered services shall be considered rendered in good faith;

(B) such policies and procedures shall be

developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

The rules shall be applicable for both MCO coverage and fee-for-service coverage.

If the fee-for-service system is ultimately determined to have been responsible for coverage on the date of service, the Department shall provide for an extended period for claims submission outside the standard timely filing requirements.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a

quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

(2) The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(3) The metrics shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, ~~pursuant to this amendatory Act of the 100th General Assembly,~~ the Department shall post an analysis of MCO claims processing and

payment performance on its website every 3 ~~6~~ months. Such analysis shall include a review and evaluation of all Medicaid claims that were paid, denied, rejected, or otherwise adjudicated by each MCO in the preceding 3 months and were submitted to an MCO by a provider that submitted at least 20 Medicaid claims to that MCO during the period. The review and evaluation shall state ~~a representative sample of hospital claims that are rejected and denied for clean and unclean claims and~~ the top 5 reasons for the rejection or denial of clean and unclean claims and the time required for claim adjudication and payment, including identifying: ~~such actions and timeliness of claims adjudication~~

(1) the total number of claims, by MCO, in the review and evaluation;

(2) the percentage of all such claims, by MCO, that were clean claims;

(3) the percentage of all claims, by MCO, that the MCO paid within 30 days of receiving the claim, and the percentage of all claims the MCO paid within 90 days of receiving the claim;

(4) the percentage of clean claims the MCO paid within 30 days of receiving the claim, and the percentage of clean claims the MCO paid within 90 days of receiving the claim;

(5) the aggregate dollar amounts of those claims identified in paragraphs (3) and (4).

Individual providers that submitted claims that are included in any Department review and evaluation required by this subsection may request, and the Department shall provide to such provider within 14 days thereafter, the data used by the Department in its review and analysis that pertains to claims submitted by that provider. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

~~, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims.~~

(g-8) Dispute resolution process. The Department shall maintain a provider complaint portal through which a provider can submit to the Department unresolved disputes with an MCO. An unresolved dispute means an MCO's decision that denies in whole or in part a claim for reimbursement to a provider for health care services rendered by the provider to an enrollee of the MCO with which the provider disagrees. Disputes shall not be submitted to the portal until the provider has availed itself of the MCO's internal dispute resolution process. Disputes that are submitted to the MCO internal dispute resolution process may be submitted to the Department of Healthcare and Family Services' complaint portal no sooner than 30 days after submitting to the MCO's internal process and not later than 30 days after the unsatisfactory resolution of the internal MCO process or 60 days after submitting the

dispute to the MCO internal process. Multiple claim disputes involving the same MCO may be submitted in one complaint, regardless of whether the claims are for different enrollees, when the specific reason for non-payment of the claims involves a common question of fact or policy. Within 10 business days of receipt of a complaint, the Department shall present such disputes to the appropriate MCO, which shall then have 30 days to issue its written proposal to resolve the dispute. The Department may grant one 30-day extension of this time frame to one of the parties to resolve the dispute. If the dispute remains unresolved at the end of this time frame or the provider is not satisfied with the MCO's written proposal to resolve the dispute, the provider may, within 30 days, request the Department to review the dispute and make a final determination. Within 30 days of the request for Department review of the dispute, both the provider and the MCO shall present all relevant information to the Department for resolution and make individuals with knowledge of the issues available to the Department for further inquiry if needed. Within 30 days of receiving the relevant information on the dispute, or the lapse of the period for submitting such information, the Department shall issue a written decision on the dispute based on contractual terms between the provider and the MCO, contractual terms between the MCO and the Department of Healthcare and Family Services and applicable Medicaid policy. The decision of the Department shall be

final. By January 1, 2020, the Department shall establish by rule further details of this dispute resolution process. Disputes between MCOs and providers presented to the Department for resolution are not contested cases, as defined in Section 1-30 of the Illinois Administrative Procedure Act, conferring any right to an administrative hearing.

(g-9)(1) The Department shall publish annually on its website a report on the calculation of each managed care organization's medical loss ratio showing the following:

(A) Premium revenue, with appropriate adjustments.

(B) Benefit expense, setting forth the aggregate amount spent for the following:

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

(vi) Expenses for activities that improve health care quality as allowed by the Department.

(2) The medical loss ratio shall be calculated consistent with federal law and regulation following a claims runout period determined by the Department.

(3) The report shall also include the total amounts of all Hospital Assessment Program-related payments made to the MCO, and whether such amounts exceed the actual increased amounts paid by the MCO to providers as a result of HAP-associated rate

increases.

(g-10)(1) "Liability effective date" means the date on which an MCO becomes responsible for payment for medically necessary and covered services rendered by a provider to one of its enrollees in accordance with the contract terms between the MCO and the provider. The liability effective date shall be the later of:

(A) The execution date of a network participation contract agreement.

(B) The date the provider or its representative submits to the MCO the complete and accurate standardized roster form for the provider in the format approved by the Department.

(C) The provider effective date contained within the Department's provider enrollment subsystem within the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) System.

(2) The standardized roster form may be submitted to the MCO at the same time that the provider submits an enrollment application to the Department through IMPACT.

(3) By October 1, 2019, the Department shall require all MCOs to update their provider directory with information for new practitioners of existing contracted providers within 30 days of receipt of a complete and accurate standardized roster template in the format approved by the Department provided that the provider is effective in the Department's provider

enrollment subsystem within the IMPACT system. Such provider directory shall be readily accessible for purposes of selecting an approved health care provider and comply with all other federal and State requirements.

(g-11) The Department shall work with relevant stakeholders on the development of operational guidelines to enhance and improve operational performance of Illinois' Medicaid managed care program, including, but not limited to, improving provider billing practices, reducing claim rejections and inappropriate payment denials, and standardizing processes, procedures, definitions, and response timelines, with the goal of reducing provider and MCO administrative burdens and conflict. The Department shall include a report on the progress of these program improvements and other topics in its Fiscal Year 2020 annual report to the General Assembly.

(g-12) Notwithstanding any other provision of law, if the Department or an MCO requires submission of a claim for payment in a non-electronic format, a provider shall always be afforded a period of no less than 90 business days, as a correction period, following any notification of rejection by either the Department or the MCO to correct errors or omissions in the original submission.

Under no circumstances, either by an MCO or under the State's fee-for-service system, shall a provider be denied payment for failure to comply with any timely submission

requirements under this Code or under any existing contract, unless the non-electronic format claim submission occurs after the initial 180 days following the latest date of service on the claim, or after the 90 business days correction period following notification to the provider of rejection or denial of payment.

At the time of payment for a claim, an MCO shall report to the provider the payment components applicable to the payment, including the base rate, the Diagnosis-Related Group (DRG) or Enhanced Ambulatory Procedure Grouping (EAPG) group and weight, any add-ons or adjustors, and any interest.

(g-13) The Department shall audit on a quarterly basis a representative sample of claims that each MCO pays to a representative sample of hospitals to determine if the MCOs are accurately paying claims, including the base rate, the DRG or EAPG group and weight, any add-ons or adjustors, and any interest.

(1) If the Department finds that an MCO has improperly denied or underpaid on a claim, the Department shall promptly communicate the underpayment to the MCO and provider, and take such steps as necessary to see that the amount due is paid.

(2) The Department shall also investigate whether the error affected other providers, and if so, notify affected providers.

(3) The findings of the audits shall be included in

the quarterly MCO Performance Metrics Report under subsection (g-6).

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(j) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form that grants to the health care provider permission to release the recipient's health care information to the recipient's insurance carrier.

(k) The Department of Healthcare and Family Services, managed care organizations, a statewide organization

representing hospitals, and a statewide organization representing safety-net hospitals shall explore ways to support billing departments in safety-net hospitals.

(l) The requirements of this Section added by Public Act 102-4 ~~this amendatory Act of the 102nd General Assembly~~ shall apply to services provided on or after the first day of the month that begins 60 days after April 27, 2021 (the effective date of Public Act 102-4) ~~this amendatory Act of the 102nd General Assembly~~.

(m) MCOs operated as part of or by any unit of State or local government shall segregate any Medicaid funds received from the State or any State agency for payments to providers separately from the governmental entity's general operating and other funds and shall use such Medicaid funds only for the Medicaid purposes for which the funds were paid to it by the State or State agency.

(Source: P.A. 101-209, eff. 8-5-19; 102-4, eff. 4-27-21; 102-43, eff. 7-6-21; 102-144, eff. 1-1-22; 102-454, eff. 8-20-21; revised 10-5-21.)

(305 ILCS 5/5A-12.7)

(Section scheduled to be repealed on December 31, 2022)

Sec. 5A-12.7. Continuation of hospital access payments on and after July 1, 2020.

(a) To preserve and improve access to hospital services, for hospital services rendered on and after July 1, 2020, the

Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals or require capitated managed care organizations to make payments as set forth in this Section. Payments under this Section are not due and payable, however, until: (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment or directed payment preprint; and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act. In determining the hospital access payments authorized under subsection (g) of this Section, if a hospital ceases to qualify for payments from the pool, the payments for all hospitals continuing to qualify for payments from such pool shall be uniformly adjusted to fully expend the aggregate net amount of the pool, with such adjustment being effective on the first day of the second month following the date the hospital ceases to receive payments from such pool.

(b) Amounts moved into claims-based rates and distributed in accordance with Section 14-12 shall remain in those claims-based rates.

(c) Graduate medical education.

(1) The calculation of graduate medical education payments shall be based on the hospital's Medicare cost report ending in Calendar Year 2018, as reported in the Healthcare Cost Report Information System file, release date September 30, 2019. An Illinois hospital reporting

intern and resident cost on its Medicare cost report shall be eligible for graduate medical education payments.

(2) Each hospital's annualized Medicaid Intern Resident Cost is calculated using annualized intern and resident total costs obtained from Worksheet B Part I, Columns 21 and 22 the sum of Lines 30-43, 50-76, 90-93, 96-98, and 105-112 multiplied by the percentage that the hospital's Medicaid days (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18, and 32) comprise of the hospital's total days (Worksheet S3 Part I, Column 8, Lines 14, 16-18, and 32).

(3) An annualized Medicaid indirect medical education (IME) payment is calculated for each hospital using its IME payments (Worksheet E Part A, Line 29, Column 1) multiplied by the percentage that its Medicaid days (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18, and 32) comprise of its Medicare days (Worksheet S3 Part I, Column 6, Lines 2, 3, 4, 14, and 16-18).

(4) For each hospital, its annualized Medicaid Intern Resident Cost and its annualized Medicaid IME payment are summed, and, except as capped at 120% of the average cost per intern and resident for all qualifying hospitals as calculated under this paragraph, is multiplied by 22.6% to determine the hospital's final graduate medical education payment. Each hospital's average cost per intern and resident shall be calculated by summing its total

annualized Medicaid Intern Resident Cost plus its annualized Medicaid IME payment and dividing that amount by the hospital's total Full Time Equivalent Residents and Interns. If the hospital's average per intern and resident cost is greater than 120% of the same calculation for all qualifying hospitals, the hospital's per intern and resident cost shall be capped at 120% of the average cost for all qualifying hospitals.

(d) Fee-for-service supplemental payments. Each Illinois hospital shall receive an annual payment equal to the amounts below, to be paid in 12 equal installments on or before the seventh State business day of each month, except that no payment shall be due within 30 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable.

(1) For critical access hospitals, $385 per covered inpatient day contained in paid fee-for-service claims and $530 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(2) For safety-net hospitals, $960 per covered inpatient day contained in paid fee-for-service claims and $625 per paid fee-for-service outpatient claim for dates

of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(3) For long term acute care hospitals, $295 per covered inpatient day contained in paid fee-for-service claims for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(4) For freestanding psychiatric hospitals, $125 per covered inpatient day contained in paid fee-for-service claims and $130 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(5) For freestanding rehabilitation hospitals, $355 per covered inpatient day contained in paid fee-for-service claims for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(6) For all general acute care hospitals and high Medicaid hospitals as defined in subsection (f), $350 per covered inpatient day for dates of service in Calendar Year 2019 contained in paid fee-for-service claims and $620 per paid fee-for-service outpatient claim in the Department's Enterprise Data Warehouse as of May 11, 2020.

(7) Alzheimer's treatment access payment. Each Illinois academic medical center or teaching hospital, as defined in Section 5-5e.2 of this Code, that is identified as the primary hospital affiliate of one of the Regional

Alzheimer's Disease Assistance Centers, as designated by the Alzheimer's Disease Assistance Act and identified in the Department of Public Health's Alzheimer's Disease State Plan dated December 2016, shall be paid an Alzheimer's treatment access payment equal to the product of the qualifying hospital's State Fiscal Year 2018 total inpatient fee-for-service days multiplied by the applicable Alzheimer's treatment rate of $226.30 for hospitals located in Cook County and $116.21 for hospitals located outside Cook County.

(e) The Department shall require managed care organizations (MCOs) to make directed payments and pass-through payments according to this Section. Each calendar year, the Department shall require MCOs to pay the maximum amount out of these funds as allowed as pass-through payments under federal regulations. The Department shall require MCOs to make such pass-through payments as specified in this Section. The Department shall require the MCOs to pay the remaining amounts as directed Payments as specified in this Section. The Department shall issue payments to the Comptroller by the seventh business day of each month for all MCOs that are sufficient for MCOs to make the directed payments and pass-through payments according to this Section. The Department shall require the MCOs to make pass-through payments and directed payments using electronic funds transfers (EFT), if the hospital provides the information

necessary to process such EFTs, in accordance with directions provided monthly by the Department, within 7 business days of the date the funds are paid to the MCOs, as indicated by the "Paid Date" on the website of the Office of the Comptroller if the funds are paid by EFT and the MCOs have received directed payment instructions. If funds are not paid through the Comptroller by EFT, payment must be made within 7 business days of the date actually received by the MCO. The MCO will be considered to have paid the pass-through payments when the payment remittance number is generated or the date the MCO sends the check to the hospital, if EFT information is not supplied. If an MCO is late in paying a pass-through payment or directed payment as required under this Section (including any extensions granted by the Department), it shall pay a penalty, unless waived by the Department for reasonable cause, to the Department equal to 5% of the amount of the pass-through payment or directed payment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each 30-day period thereafter. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this Section shall not be reduced as a consequence of payments made under this subsection. The Department shall publish and maintain on its website for a period of no less than 8 calendar quarters, the quarterly calculation of directed payments and pass-through payments owed to each hospital from each MCO. All

calculations and reports shall be posted no later than the first day of the quarter for which the payments are to be issued.

(f)(1) For purposes of allocating the funds included in capitation payments to MCOs, Illinois hospitals shall be divided into the following classes as defined in administrative rules:

(A) Critical access hospitals.

(B) Safety-net hospitals, except that stand-alone children's hospitals that are not specialty children's hospitals will not be included.

(C) Long term acute care hospitals.

(D) Freestanding psychiatric hospitals.

(E) Freestanding rehabilitation hospitals.

(F) High Medicaid hospitals. As used in this Section, "high Medicaid hospital" means a general acute care hospital that is not a safety-net hospital or critical access hospital and that has a Medicaid Inpatient Utilization Rate above 30% or a hospital that had over 35,000 inpatient Medicaid days during the applicable period. For the period July 1, 2020 through December 31, 2020, the applicable period for the Medicaid Inpatient Utilization Rate (MIUR) is the rate year 2020 MIUR and for the number of inpatient days it is State fiscal year 2018. Beginning in calendar year 2021, the Department shall use the most recently determined MIUR, as defined in

subsection (h) of Section 5-5.02, and for the inpatient day threshold, the State fiscal year ending 18 months prior to the beginning of the calendar year. For purposes of calculating MIUR under this Section, children's hospitals and affiliated general acute care hospitals shall be considered a single hospital.

(G) General acute care hospitals. As used under this Section, "general acute care hospitals" means all other Illinois hospitals not identified in subparagraphs (A) through (F).

(2) Hospitals' qualification for each class shall be assessed prior to the beginning of each calendar year and the new class designation shall be effective January 1 of the next year. The Department shall publish by rule the process for establishing class determination.

(g) Fixed pool directed payments. Beginning July 1, 2020, the Department shall issue payments to MCOs which shall be used to issue directed payments to qualified Illinois safety-net hospitals and critical access hospitals on a monthly basis in accordance with this subsection. Prior to the beginning of each Payout Quarter beginning July 1, 2020, the Department shall use encounter claims data from the Determination Quarter, accepted by the Department's Medicaid Management Information System for inpatient and outpatient services rendered by safety-net hospitals and critical access hospitals to determine a quarterly uniform per unit add-on for

each hospital class.

(1) Inpatient per unit add-on. A quarterly uniform per diem add-on shall be derived by dividing the quarterly Inpatient Directed Payments Pool amount allocated to the applicable hospital class by the total inpatient days contained on all encounter claims received during the Determination Quarter, for all hospitals in the class.

(A) Each hospital in the class shall have a quarterly inpatient directed payment calculated that is equal to the product of the number of inpatient days attributable to the hospital used in the calculation of the quarterly uniform class per diem add-on, multiplied by the calculated applicable quarterly uniform class per diem add-on of the hospital class.

(B) Each hospital shall be paid 1/3 of its quarterly inpatient directed payment in each of the 3 months of the Payout Quarter, in accordance with directions provided to each MCO by the Department.

(2) Outpatient per unit add-on. A quarterly uniform per claim add-on shall be derived by dividing the quarterly Outpatient Directed Payments Pool amount allocated to the applicable hospital class by the total outpatient encounter claims received during the Determination Quarter, for all hospitals in the class.

(A) Each hospital in the class shall have a quarterly outpatient directed payment calculated that

is equal to the product of the number of outpatient encounter claims attributable to the hospital used in the calculation of the quarterly uniform class per claim add-on, multiplied by the calculated applicable quarterly uniform class per claim add-on of the hospital class.

(B) Each hospital shall be paid 1/3 of its quarterly outpatient directed payment in each of the 3 months of the Payout Quarter, in accordance with directions provided to each MCO by the Department.

(3) Each MCO shall pay each hospital the Monthly Directed Payment as identified by the Department on its quarterly determination report.

(4) Definitions. As used in this subsection:

(A) "Payout Quarter" means each 3 month calendar quarter, beginning July 1, 2020.

(B) "Determination Quarter" means each 3 month calendar quarter, which ends 3 months prior to the first day of each Payout Quarter.

(5) For the period July 1, 2020 through December 2020, the following amounts shall be allocated to the following hospital class directed payment pools for the quarterly development of a uniform per unit add-on:

(A) $2,894,500 for hospital inpatient services for critical access hospitals.

(B) $4,294,374 for hospital outpatient services

for critical access hospitals.

(C) $29,109,330 for hospital inpatient services for safety-net hospitals.

(D) $35,041,218 for hospital outpatient services for safety-net hospitals.

(h) Fixed rate directed payments. Effective July 1, 2020, the Department shall issue payments to MCOs which shall be used to issue directed payments to Illinois hospitals not identified in paragraph (g) on a monthly basis. Prior to the beginning of each Payout Quarter beginning July 1, 2020, the Department shall use encounter claims data from the Determination Quarter, accepted by the Department's Medicaid Management Information System for inpatient and outpatient services rendered by hospitals in each hospital class identified in paragraph (f) and not identified in paragraph (g). For the period July 1, 2020 through December 2020, the Department shall direct MCOs to make payments as follows:

(1) For general acute care hospitals an amount equal to $1,750 multiplied by the hospital's category of service 20 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 20 for the determination quarter.

(2) For general acute care hospitals an amount equal to $160 multiplied by the hospital's category of service 21 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for

category of service 21 for the determination quarter.

(3) For general acute care hospitals an amount equal to $80 multiplied by the hospital's category of service 22 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 22 for the determination quarter.

(4) For general acute care hospitals an amount equal to $375 multiplied by the hospital's category of service 24 case mix index for the determination quarter multiplied by the hospital's total number of category of service 24 paid EAPG (EAPGs) for the determination quarter.

(5) For general acute care hospitals an amount equal to $240 multiplied by the hospital's category of service 27 and 28 case mix index for the determination quarter multiplied by the hospital's total number of category of service 27 and 28 paid EAPGs for the determination quarter.

(6) For general acute care hospitals an amount equal to $290 multiplied by the hospital's category of service 29 case mix index for the determination quarter multiplied by the hospital's total number of category of service 29 paid EAPGs for the determination quarter.

(7) For high Medicaid hospitals an amount equal to $1,800 multiplied by the hospital's category of service 20 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for

category of service 20 for the determination quarter.

(8) For high Medicaid hospitals an amount equal to $160 multiplied by the hospital's category of service 21 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 21 for the determination quarter.

(9) For high Medicaid hospitals an amount equal to $80 multiplied by the hospital's category of service 22 case mix index for the determination quarter multiplied by the hospital's total number of inpatient admissions for category of service 22 for the determination quarter.

(10) For high Medicaid hospitals an amount equal to $400 multiplied by the hospital's category of service 24 case mix index for the determination quarter multiplied by the hospital's total number of category of service 24 paid EAPG outpatient claims for the determination quarter.

(11) For high Medicaid hospitals an amount equal to $240 multiplied by the hospital's category of service 27 and 28 case mix index for the determination quarter multiplied by the hospital's total number of category of service 27 and 28 paid EAPGs for the determination quarter.

(12) For high Medicaid hospitals an amount equal to $290 multiplied by the hospital's category of service 29 case mix index for the determination quarter multiplied by the hospital's total number of category of service 29 paid

EAPGs for the determination quarter.

(13) For long term acute care hospitals the amount of $495 multiplied by the hospital's total number of inpatient days for the determination quarter.

(14) For psychiatric hospitals the amount of $210 multiplied by the hospital's total number of inpatient days for category of service 21 for the determination quarter.

(15) For psychiatric hospitals the amount of $250 multiplied by the hospital's total number of outpatient claims for category of service 27 and 28 for the determination quarter.

(16) For rehabilitation hospitals the amount of $410 multiplied by the hospital's total number of inpatient days for category of service 22 for the determination quarter.

(17) For rehabilitation hospitals the amount of $100 multiplied by the hospital's total number of outpatient claims for category of service 29 for the determination quarter.

(18) Each hospital shall be paid 1/3 of their quarterly inpatient and outpatient directed payment in each of the 3 months of the Payout Quarter, in accordance with directions provided to each MCO by the Department.

(19) Each MCO shall pay each hospital the Monthly Directed Payment amount as identified by the Department on

its quarterly determination report.

Notwithstanding any other provision of this subsection, if the Department determines that the actual total hospital utilization data that is used to calculate the fixed rate directed payments is substantially different than anticipated when the rates in this subsection were initially determined (for unforeseeable circumstances such as the COVID-19 pandemic), the Department may adjust the rates specified in this subsection so that the total directed payments approximate the total spending amount anticipated when the rates were initially established.

Definitions. As used in this subsection:

(A) "Payout Quarter" means each calendar quarter, beginning July 1, 2020.

(B) "Determination Quarter" means each calendar quarter which ends 3 months prior to the first day of each Payout Quarter.

(C) "Case mix index" means a hospital specific calculation. For inpatient claims the case mix index is calculated each quarter by summing the relative weight of all inpatient Diagnosis-Related Group (DRG) claims for a category of service in the applicable Determination Quarter and dividing the sum by the number of sum total of all inpatient DRG admissions for the category of service for the associated claims. The case mix index for outpatient claims is calculated

each quarter by summing the relative weight of all paid EAPGs in the applicable Determination Quarter and dividing the sum by the sum total of paid EAPGs for the associated claims.

(i) Beginning January 1, 2021, the rates for directed payments shall be recalculated in order to spend the additional funds for directed payments that result from reduction in the amount of pass-through payments allowed under federal regulations. The additional funds for directed payments shall be allocated proportionally to each class of hospitals based on that class' proportion of services.

(j) Pass-through payments.

(1) For the period July 1, 2020 through December 31, 2020, the Department shall assign quarterly pass-through payments to each class of hospitals equal to one-fourth of the following annual allocations:

(A) $390,487,095 to safety-net hospitals.

(B) $62,553,886 to critical access hospitals.

(C) $345,021,438 to high Medicaid hospitals.

(D) $551,429,071 to general acute care hospitals.

(E) $27,283,870 to long term acute care hospitals.

(F) $40,825,444 to freestanding psychiatric hospitals.

(G) $9,652,108 to freestanding rehabilitation hospitals.

(2) The pass-through payments shall at a minimum

ensure hospitals receive a total amount of monthly payments under this Section as received in calendar year 2019 in accordance with this Article and paragraph (1) of subsection (d-5) of Section 14-12, exclusive of amounts received through payments referenced in subsection (b).

(3) For the calendar year beginning January 1, 2021, and each calendar year thereafter, each hospital's pass-through payment amount shall be reduced proportionally to the reduction of all pass-through payments required by federal regulations.

(k) At least 30 days prior to each calendar year, the Department shall notify each hospital of changes to the payment methodologies in this Section, including, but not limited to, changes in the fixed rate directed payment rates, the aggregate pass-through payment amount for all hospitals, and the hospital's pass-through payment amount for the upcoming calendar year.

(l) Notwithstanding any other provisions of this Section, the Department may adopt rules to change the methodology for directed and pass-through payments as set forth in this Section, but only to the extent necessary to obtain federal approval of a necessary State Plan amendment or Directed Payment Preprint or to otherwise conform to federal law or federal regulation.

(m) As used in this subsection, "managed care organization" or "MCO" means an entity which contracts with

the Department to provide services where payment for medical services is made on a capitated basis, excluding contracted entities for dual eligible or Department of Children and Family Services youth populations.

(n) In order to address the escalating infant mortality rates among minority communities in Illinois, the State shall, subject to appropriation, create a pool of funding of at least $50,000,000 annually to be disbursed among safety-net hospitals that maintain perinatal designation from the Department of Public Health. The funding shall be used to preserve or enhance OB/GYN services or other specialty services at the receiving hospital, with the distribution of funding to be established by rule and with consideration to perinatal hospitals with safe birthing levels and quality metrics for healthy mothers and babies.

The Department shall calculate, at least quarterly, all Hospital Assessment Program-related funds paid to each hospital, whether paid by the Department or an MCO, including the amounts integrated into rate increases and distributed in accordance with Section 14-12 as provided under subsection (b) of Section 5A-12.7, and shall provide a report to each hospital stating the total payments made in the preceding quarter and including the data and mathematical formulas supporting its calculation.

(o) In order to address the growing challenges of providing stable access to healthcare in rural Illinois,

including perinatal services, behavioral healthcare including substance use disorder services (SUDs) and other specialty services, and to expand access to telehealth services among rural communities in Illinois, the Department of Healthcare and Family Services, subject to appropriation, shall administer a program to provide at least $10,000,000 in financial support annually to critical access hospitals for delivery of perinatal and OB/GYN services, behavioral healthcare including SUDS, other specialty services and telehealth services. The funding shall be used to preserve or enhance perinatal and OB/GYN services, behavioral healthcare including SUDS, other specialty services, as well as the explanation of telehealth services by the receiving hospital, with the distribution of funding to be established by rule.

(Source: P.A. 101-650, eff. 7-7-20; 102-4, eff. 4-27-21; 102-16, eff. 6-17-21.)